TEXAS DEPARTMENT OF INSURANCE
Division of Workers' Compensation - Medical Fee Dispute Resolution (MS-48)
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MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name
Memorial Compounding Pharmacy

Respondent Name
Indemnity Insurance Company of North America

MFDR Tracking Number
M4-17-2265-01

Carrier's Austin Representative
Box Number 15

MFDR Date Received
March 27, 2017

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "The attached bills have been denied. The reconsideration was sent to but still denied. We are now requesting Medical Fee Dispute Resolution."

Amount in Dispute: $726.61

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "DOS 06/28/16 – Denied through paperbills as Provider not certified."

Response Submitted by: Optum

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
June 28, 2016	Pharmacy Services – Compound	$726.61	$726.61

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and applicable rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.502 sets out the procedures for pharmaceutical benefits.
3. 28 Texas Administrative Code §134.503 sets out the fee guideline for pharmacy services.
4. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
   - B7 – This provider was not certified/eligible to be paid for this procedure/service on this date of service.

Issues

1. Is Indemnity Insurance Company of North America's reason for denial of payment supported?
2. Is Memorial Compounding Pharmacy (Memorial) entitled to reimbursement for the compound in question?

Findings

1. Indemnity Insurance Company of North America denied the disputed compound with claim adjustment reason code B7 – "THIS PROVIDER WAS NOT CERTIFIED/ELIGIBLE TO BE PAID FOR THIS PROCEDURE/SERVICE ON THIS DATE OF SERVICE." The Texas State Board of Pharmacy provides license information for Memorial Compounding Pharmacy. License number 18996 for Memorial was issued on May 5, 1998, and expires on May 31, 2018. Services listed under this license include "Compounding Non-Sterile."

   Indemnity Insurance Company of North America failed to articulate any further defense of its denial of payment. Therefore, the division concludes that the denial of the compound in question is not supported.

2. Because Indemnity Insurance Company of North America failed to support its denial of payment, Memorial is entitled to reimbursement for the compound in question. 28 Texas Administrative Code §134.503 applies to the compound in dispute and states, in pertinent part:

   (c) The insurance carrier shall reimburse the health care provider or pharmacy processing agent for prescription drugs the lesser of:
   (1) the fee established by the following formulas based on the average wholesale price (AWP) as reported by a nationally recognized pharmaceutical price guide or other publication of pharmaceutical pricing data in effect on the day the prescription drug is dispensed:
   (A) Generic drugs: ((AWP per unit) x (number of units) x 1.25) + $4.00 dispensing fee per prescription = reimbursement amount;
   (B) Brand name drugs: ((AWP per unit) x (number of units) x 1.09) + $4.00 dispensing fee per prescription = reimbursement amount;
   (C) When compounding, a single compounding fee of $15 per prescription shall be added to the calculated total for either paragraph (1)(A) or (B) of this subsection; or
   (2) notwithstanding §133.20(e)(1) of this title (relating to Medical Bill Submission by Health Care Provider), the amount billed to the insurance carrier by the:
   (A) health care provider; or
   (B) pharmacy processing agent only if the health care provider has not previously billed the insurance carrier for the prescription drug and the pharmacy processing agent is billing on behalf of the health care provider.

   The compound ingredients in dispute were billed by listing each drug included in the compound and calculating the charge for each drug separately as required by 28 Texas Administrative Code §134.502(d)(2). Each ingredient is listed below with its corresponding reimbursement amount as applicable.

Ingredient	NDC & Type	Price/ Unit	Total Units	AWP Formula §134.503(c)(1)	Billed Amt §134.503 (c)(2)	Lesser of (c)(1) and (c)(2)
Compounding Fee	NA	NA	NA	$15.00	$15.00	$15.00
Versapro Cream Base	38779252903 Brand Name	$3.20	45.02 gm	$3.20 x 45.02 x 1.09 = $157.03	$144.06	$144.06
Ethoxy Diglycol	38779190301 Generic	$0.342	3.0 ml	$0.342 x 3 x 1.25 = $1.28	$1.02	$1.02
Bupivacaine HCl	38779052405 Generic	$45.60	1.2 gm	$45.60 x 1.2 x 1.25 = $68.40	$54.72	$54.72
Cyclobenzaprine HCl	38779039509 Generic	$46.332	1.8 gm	$46.332 x 1.8 x 1.25 = $104.25	$83.39	$83.39
Tramadol HCl	38779237409 Generic	$36.30	6.0 gm	$36.30 x 6 x 1.25 = $272.25	$217.80	$217.80

Flurbiprofen	38779036209 Generic	$36.58	4.8 gm	$36.58 x 4.8 x 1.25 = $219.48	$175.58	$175.58
Meloxicam	38779274601 Generic	$194.67	0.18 gm	$194.67 x 0.18 x 1.25 = $43.80	$35.04	$35.04
					Total	$726.61

The total allowable reimbursement is therefore $726.61. This amount is recommended.

Conclusion

For the reasons stated above, the Division finds that the requestor has established that additional reimbursement is due. As a result, the amount ordered is $726.61.

ORDER

Based on the submitted information, pursuant to Texas Labor Code Sec. 413.031 and 413.019 (if applicable), the Division has determined that the requestor is entitled to additional reimbursement for the services in dispute. The Division hereby ORDERS the respondent to remit to the requestor the amount of $726.61, plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this Order.

Authorized Signature

	Laurie Garnes	June 2, 2017
Signature	Medical Fee Dispute Resolution Officer	Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute has a right to seek review of this decision in accordance with 28 Texas Administrative Code §133.307, 37 *Texas Register* 3833, applicable to disputes filed on or after June 1, 2012.

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the Division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the Division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MFDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.